SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
Company Tracking Number:	*BRANDI LASHLEY*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Individual Life Insurance - C501LAR08P*		
Project Name/Number:	*2008 United Med Supp-Whole Life Combo/C501LAR08P*		

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Individual Life Insurance - C501LAR08P	SERFF Tr Num: MUTM-125639422	State: ArkansasLH
TOI: L07I Individual Life - Whole	SERFF Status: Closed	State Tr Num: 39090
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: BRANDI LASHLEY	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Brandi Lashley, Kim Meyerring, Stacey Payton	Disposition Date: 05/28/2008
	Date Submitted: 05/23/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 2008 United Med Supp-Whole Life Combo	Status of Filing in Domicile: Not Filed
Project Number: C501LAR08P	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: These forms are not for use in Nebraska, our state of domicile. Therefore they have not been filed for approval with the Nebraska Department of Insurance.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/28/2008	
State Status Changed: 05/28/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

Please see cover letter attached under the supporting documentation tab.

SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
Company Tracking Number:	*BRANDI LASHLEY*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Individual Life Insurance - C501LAR08P*		
Project Name/Number:	*2008 United Med Supp-Whole Life Combo/C501LAR08P*		

Company and Contact

Filing Contact Information

Brandi Lashley, Product & Advertising Compliance Analyst	brandi.lashley@mutualofomaha.com
Regulatory Affairs	(402) 351-4005 [Phone]
Omaha, NE 68175	(402) 351-5298[FAX]

Filing Company Information

United of Omaha Life Insurance Company	CoCode: 69868	State of Domicile: Nebraska
Mutual of Omaha Plaza	Group Code: 261	Company Type: Life Insurance
Omaha, NE 68175	Group Name:	State ID Number:
(402) 351-6420 ext. [Phone]	FEIN Number: 47-0322111	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	$50.00	05/23/2008	20490022

SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	05/28/2008	05/28/2008

SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
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TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
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Project Name/Number:	*2008 United Med Supp-Whole Life Combo/C501LAR08P*		

Disposition

Disposition Date: 05/28/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
Company Tracking Number:	*BRANDI LASHLEY*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
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Project Name/Number:	*2008 United Med Supp-Whole Life Combo/C501LAR08P*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Memo of Variability for Data Pages		Yes
Supporting Document	Memo of Variability for Applications		Yes
Supporting Document	AR Credit Card Cert		Yes
Supporting Document	AR Fee Schedule Cert		Yes
Supporting Document	AR Read Cert		Yes
Form	Whole Life Insurance Policy		Yes
Form	Whole Life Insurance/Medicare Supplement Application		Yes
Form	Whole Life Insurance Addendum Application		Yes

SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
Company Tracking Number:	*BRANDI LASHLEY*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
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Form Schedule

Lead Form Number: C501LAR08P

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	C501LAR08P	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Whole Life Insurance Policy	Initial		51	Policy C501LAR08P.pdf
	UA5916-03	Application/Enrollment Form	Whole Life Insurance/Medicare Supplement Application	Initial		51	Application UA5916-03 (AR).pdf
	C447LNA08A	Application/Enrollment Form	Whole Life Insurance Addendum Application	Initial		50	Application C447LNA08A (Nat'l).pdf

UNITED *of* OMAHA LIFE INSURANCE COMPANY
Mutual of Omaha Plaza, Omaha, NE 68175

a stock company

Insured	[John J. Doe]
Face Amount	[$2,000]
Issue Date	[May 1, 2005]
Policy Number	[1234567]

Whole Life Insurance Policy

United of Omaha Life Insurance Company will pay the death benefit of this policy to the Beneficiary as soon as possible after we receive proof at our home office in Omaha, Nebraska, that the insured died while the policy was in force. On the maturity date we will pay you the death benefit, if the insured is then living and the policy is in force.

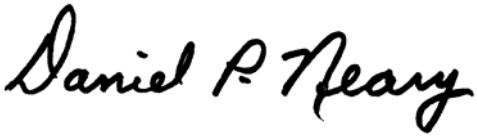
Right to Return This Policy. If you are not satisfied with your policy, return it to us or our representatives within 20 days (or 30 days if your purchase is a replacement of another life insurance or annuity policy) after you receive it. We will refund the premium paid and cancel your policy as of the date any insurance became effective.

READ YOUR POLICY CAREFULLY.
This policy is a legal contract between you and us.

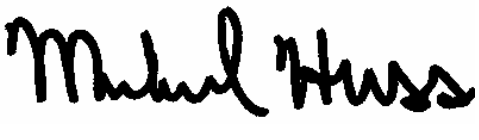
WHOLE LIFE INSURANCE POLICY

- **Life Insurance Payable at the Death of the Insured**
- **Policy Matures on the Policy Anniversary Date Following the Insured's 100th Birthday**
- **Premiums Payable to the Policy Anniversary Date Following the Insured's 100th Birthday**
- **Non-Participating - No Dividends**

For customer service or questions about your coverage, please call [XXX-XXX-XXXX].



Chairman of the Board and Chief Executive Officer



Corporate Secretary

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POLICY DATA

Insured	[John J. Doe]	**Policy Number**	[UA1234567]
Sex	[Male]	**Issue Date**	[March 1, 2008]
Issue Age	[65]	**Maturity Date**	[March 1, 2067]
Rate Class	[Standard]		
Risk Class	[Standard Non-Tobacco]		

Premium Payment Mode	[Annual]
Face Amount	$[5,000]
Policyowner	See application or endorsement
Beneficiary	See application or endorsement

SCHEDULE OF BENEFITS

Form	Benefit	Annual Premium	Years Payable
C501LAR08P	Life Insurance	$[401.50]	[35]
TOTAL ANNUAL PREMIUM		$[401.50]	

The premium for the premium payment mode selected includes a modal policy fee of $[36.00]. The premium due date is the issue date and the same day each [12 months] thereafter until the maturity date.

Premiums by Premium Payment Mode

Annual	Semiannual	Quarterly	[Bank Service Plan]
$[401.50]	$[200.75]	$[100.38]	$[33.46]

TABLE OF POLICY VALUES

The values shown below are based on the policy's face amount, the nonforfeiture interest rate and the mortality table shown below.

End of Policy Year	Death Benefit	Cash Value	Reduced Paid-up Life Insurance
[1	$5,000	$0	$0
2	$5,000	0	0
3	$5,000	150	290
4	$5,000	305	575
5	$5,000	460	840
6	$5,000	620	1,100
7	$5,000	775	1,340
8	$5,000	935	1,570
9	$5,000	1,095	1,795
10	$5,000	1,250	1,995
11	$5,000	1,410	2,195
12	$5,000	1,565	2,380
13	$5,000	1,720	2,555
14	$5,000	1,875	2,725
15	$5,000	2,025	2,880
16	$5,000	2,165	3,015
17	$5,000	2,305	3,150
18	$5,000	2,445	3,280
19	$5,000	2,575	3,395
20	$5,000	2,705	3,510
At Age			
75	$5,000	1,250	1,995
100	$5,000	5,000	5,000]

Nonforfeiture Factor: [11.20881]
Nonforfeiture Interest Rate: [5.00%]

Values are based on the Commissioners [2001] Standard Ordinary Mortality Table, Male or Female, as applicable to the insured, and the nonforfeiture interest rate shown above.

TABLE OF CONTENTS PAGE

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DEFINITIONS

Age means age last birthday.

Executive Officer means the chief executive officer, the president, any vice president, the corporate secretary or any assistant corporate secretary of United of Omaha Life Insurance Company.

Loan means, as of any date of determination, the outstanding principal amount of sums you have borrowed from this policy, plus the amount of any interest due but unpaid on that principal amount.

Our, Us, and **We** refer to United of Omaha Life Insurance Company, Omaha, Nebraska.

Payee means the person who receives payments under this policy.

Proceeds means:

(a) the death benefit; or
(b) the cash value less any Loan; or
(c) the amount payable on the policy maturity date.

Rider means a provision added to this policy to expand or limit the benefits payable.

You and **Your** refer to the owner(s) of this policy.

GENERAL PROVISIONS

Entire Contract

The entire contract is this policy, any Riders, endorsements and amendments, and the signed application(s), a copy of which is attached. All statements made in the application will, in the absence of fraud, be deemed representations and not warranties. We will not use any statement to contest this policy or deny a claim unless it is in the application.

Any change of this policy requires the written consent of an Executive Officer. No agent has the authority to change this contract or waive any of its terms.

Incontestability

Except for nonpayment of premium, we will not contest the validity of this policy after it has been in force during the lifetime of the insured for two years from the date of issue. Any contest will be based on material representations in the application.

Except for nonpayment of premium, we will not contest the validity of this policy after it has been in force during the lifetime of the insured for two years from the effective date of a reinstatement. Any contest of a reinstatement will be based on material representations in the application for reinstatement.

If this policy is issued as a conversion from another life insurance coverage, then the contestable period for the amount of the insurance converted without evidence of insurability will be measured from the issue date of the original coverage.

Misstatement of Age or Sex

If the Age or sex of the insured has been misstated, the amount payable will be the amount which the premium paid would have bought at the correct Age and sex.

Nonparticipating

No dividends will be paid. This policy will not share in our surplus or earnings.

Policy Dates

The following dates are measured from the date of issue:

(a) policy months;
(b) policy years;
(c) policy anniversaries; and
(d) premium due dates.

EXCLUSION

Suicide

We will not pay the death benefit if the insured's death results from suicide, while sane or insane, within two years from the date of issue. Instead, we will pay the sum of the premiums paid less any Loan.

If the policy is issued as a conversion without evidence of insurability from another life insurance coverage, then the exclusion period for suicide will be measured from the issue date of the original policy.

OWNER AND BENEFICIARY

Ownership

The owner is:

(a) the insured; or
(b) the applicant if other than the insured.

While the insured is alive, only you, the owner, may exercise the rights under this policy. You may name a new owner as described in the **Assignment** provision.

Assignment

You may name a new owner of this policy by making an absolute assignment or pledge it as collateral by making a collateral assignment. However, you may not change the owner during the first three policy years unless:

(a) we approve the change; or
(b) a court of competent jurisdiction orders the change.

Any assignment must be in writing. No assignment will be binding on us until we receive and approve it. We are not responsible for the validity or effect of any assignment. If the beneficiary is irrevocable, you may change the owner or make a collateral assignment only if the beneficiary agrees in writing.

The rights of a beneficiary are subject to a collateral assignment.

Beneficiary

The beneficiary is named in the application. You may change the beneficiary at any time unless the beneficiary is irrevocable. However, you may not designate a beneficiary as irrevocable during the first three policy years unless:

(a) we approve the designation; or
(b) a court of competent jurisdiction orders the designation.

To change a beneficiary, send a written request to us. When we record, acknowledge, and when required, approve it, the change will be effective as of the date you signed the request. The change will not apply to any payments made or other action we take before recording.

If the beneficiary is irrevocable, you may make a change only if the irrevocable beneficiary agrees in writing.

DEATH BENEFIT

Death Benefit

If we do not pay the death benefit within 30 days from the date proof of the insured's death is furnished to us, we will pay 8% interest on the Proceeds.

The death benefit equals:

(a) the face amount shown on the data pages; or
(b) the reduced paid-up life insurance amount for the applicable policy year if the policy is continued as a nonforfeiture option, as provided in the POLICY VALUES AND NONFORFEITURE OPTION section.

The death benefit will be adjusted by:

(a) adding any death benefit provided by Riders;
(b) adding any premium refund;
(c) deducting any Loan; and
(d) deducting any unpaid premium.

PREMIUMS AND REINSTATEMENT

Consideration

The consideration for this policy is the application and the payment of the first premium. The policy will remain in force if the premiums are paid as shown on the data pages.

Payment of Premiums

Premiums are payable in advance at our home office or to an authorized agent on or before the premium due date. Premiums may be paid:

(a) annually;
(b) semiannually; or
(c) at other intervals offered by us.

We will send you a receipt signed by an Executive Officer if you request one.

Grace Period

We will allow a grace period of 31 days for the payment of each premium except the first. This policy will remain in force during the grace period. If the insured dies on the premium due date or during the grace period, the premium for the policy month in which death occurs will be deducted in determining the death benefit.

Nonpayment of Premiums

If any premium is not paid by the end of the grace period, this policy will terminate as of the premium due date except as provided in the POLICY VALUES AND NONFORFEITURE OPTION section. You may reinstate this policy to a premium-paying basis by meeting the requirements of the **Reinstatement** provision.

Reinstatement

If this policy terminates due to nonpayment of premium, and if the policy has not been surrendered for cash, the policy may be reinstated within three years of the premium due date of the unpaid premium.

Reinstatement is subject to the following:

(a) written application signed by you and the insured;
(b) evidence of insurability that we accept;
(c) payment of the sum of (1) the amount of premium you owe for the period of nonpayment plus interest on that amount at the annual interest rate of 6.00% compounding monthly; plus (2) the amount of premium from the beginning of the policy month in which reinstatement occurs to the next premium due date; and
(d) payment or reestablishment of any outstanding Loan.

Premium Refund at Death

Any premium paid for the period beyond the policy month in which the insured dies will be refunded and paid to the beneficiary as part of the death benefit.

POLICY VALUES AND NONFORFEITURE OPTION

Surrender for Cash

While the insured is alive, you may surrender this policy for its cash value less any Loan. Cash values at the end of certain policy years, assuming there is no Loan, are shown on the data pages. The cash value during a policy year will be based on the time elapsed and the premiums paid to date. The cash value does not include any Rider benefits unless provided for in the Rider.

Any premium paid for the period beyond the policy month of surrender will be refunded. If you surrender the policy within 60 days after the premium due date of an unpaid premium, we will determine the cash value as of that premium due date.

If this policy is in force as reduced paid-up life insurance, you may surrender it for the cash value less any Loan. The cash value will be the present value of the remaining benefits at the time of surrender. This amount will be based on the mortality table and the nonforfeiture interest rate shown on the data pages. If you surrender the policy within 30 days after a policy anniversary, the cash value will be determined as of that anniversary.

We may defer payment of the cash value for six months.

Reduced Paid-up Life Insurance Option

If you have not surrendered the policy for cash within 60 days after the premium due date of an unpaid premium, the policy will automatically continue as reduced paid-up life insurance. The reduced paid-up life insurance will be in effect beginning on the premium due date of the unpaid premium. No further premiums must then be paid. Rider benefits are not included unless provided for in the Rider. The cash value, less any Loan, will be used as a net single premium at the attained Age of the insured to determine the amount of reduced paid-up life insurance. The amounts of reduced paid-up insurance at the end of certain policy years, assuming there is no Loan, are shown on the data pages.

Computation of Policy Values

Values are computed using the Standard Nonforfeiture Value Method. Values will be equal to or greater than the minimum cash surrender values required by the state in which this policy is delivered. The method of computing values has been filed with the insurance department of the state in which this policy is delivered.

Values are based on the mortality table and the nonforfeiture interest rate shown on the data pages. The mortality table is adjusted to Age last birthday. Deaths are assumed to occur at the end of the policy year.

LOANS AND REPAYMENTS

Loans

If this policy is in force, you may obtain a Loan for part or all of the cash value less:

(a) the interest that will accrue on the Loan to the end of the policy year in which the Loan is made;
(b) any existing Loan; and
(c) any premium due.

We will charge interest on the Loan at the rate of 7.4% payable in advance. Because interest on the Loan is payable in advance, the effective annual interest rate is 8.00%. Interest is due on the date the Loan is made and on each policy anniversary thereafter. Any payments of interest not paid when due will be added to the principal amount of the Loan and bear interest at the same rate payable on the Loan. All calculations of interest will be made on the basis of actual days elapsed for a 365-day year with interest compounding annually.

You must assign the policy to us as sole security for the loan.

The death benefit will be reduced by the amount of any outstanding Loan on the date of the insured's death.

We may defer making a Loan for six months unless the Loan is to pay premiums to us.

Loan Repayment

You may repay all or part of a Loan at any time while this policy is in force. At the time of repayment, we will refund any interest paid but not yet accrued on the Loan.

If you do not repay a Loan, the policy will end without value when the loan balance equals or exceeds the cash value. We will notify you of the payment necessary to keep the policy in force at least 45 days before the policy ends. The notice will be mailed to your last known address and to any collateral assignee of record.

PAYOUT OPTIONS FOR PAYMENT OF POLICY PROCEEDS

General Conditions

While the insured is alive, you may choose to have the Proceeds paid under any of the options for payment shown in the **Payout Options** provision. If you have not made a choice before the insured dies, the beneficiary may choose an option. If no option is chosen, we will make payment in a lump sum.

We will pay the Proceeds in one sum when the Proceeds are less than $2,000, or when the option of payment chosen would result in periodic payments of less than $20. Payees must receive payment in their own behalf unless we agree to another arrangement. Any option chosen is effective when we record it.

We may require proof of age or survival of the Payee.

Unless you have directed otherwise, the Payee may:

(a) choose the option for payments;
(b) change or name the person(s) who are to receive any Proceeds remaining at the death of the Payee;
(c) withdraw all or any part of any Proceeds remaining under payout option 1; or
(d) withdraw the present value of any remaining payments under payout option 2 or 3.

The guaranteed annual interest rate used in these options is 3% compounding monthly. Using a procedure approved by our Board of Directors, we may pay or credit additional interest annually.

When the last Payee dies, we will pay to the estate of that Payee any amount on deposit or the then present value of any remaining guaranteed payments.

Payout Options

1. Proceeds Held on Deposit at Interest

While the Proceeds are held by us, we will annually pay interest to the Payee or add interest to the Proceeds.

2. Income of a Specified Amount

We will pay the Proceeds in installments of a specified amount until the Proceeds with interest have been fully paid.

3. Income for a Specified Period

The Proceeds will be paid in installments for the number of years chosen. The monthly incomes for each $1,000 of Proceeds are shown in the following table. These amounts include interest. We will provide the income amounts for payments other than monthly upon request.

Monthly Income Per Each $1,000 of Proceeds

Years Chosen	Monthly Income	Years Chosen	Monthly Income	Years Chosen	Monthly Income
1	$84.47	8	$11.68	15	$6.87
2	42.86	9	10.53	16	6.53
3	28.99	10	9.61	17	6.23
4	22.06	11	8.86	18	5.96
5	17.91	12	8.24	19	5.73
6	15.14	13	7.71	20	5.51
7	13.16	14	7.26		

4. Lifetime Income

We will pay the Proceeds as a monthly income for as long as the Payee lives. The following guarantees are available:

(a) **Guaranteed Period -** The monthly income for a minimum of 10 years and as long thereafter as the original Payee lives; or
(b) **Guaranteed Amount -** The monthly income will be paid until the sum of all payments equals the Proceeds placed under this option and as long thereafter as the original Payee lives.

The monthly income will be the amount computed using one of the following bases:

(a) the Lifetime Monthly Income Table shown in this policy based on a guaranteed annual interest rate of 3% compounding monthly and the 2000a Mortality Table; or
(b) if more favorable to the Payee, our then current lifetime monthly rates for payment of policy Proceeds.

5. Lump Sum

We will pay the Proceeds in one sum.

6. Alternative Schedule

Upon request and if available, we will provide lifetime income amounts for payments less frequent than monthly, other guaranteed periods, or for joint and survivor Payees.

Lifetime Monthly Income Table for Option 4

Monthly Income for Each $1,000 of Proceeds

Age Last Birthday of Payee	Guaranteed Period		Guaranteed Amount		Age Last Birthday of Payee	Guaranteed Period		Guaranteed Amount		Age Last Birthday of Payee	Guaranteed Period		Guaranteed Amount	
	Male	Female	Male	Female		Male	Female	Male	Female		Male	Female	Male	Female
7 and under	$2.80	$2.75	$2.80	$2.75										
8	2.82	2.76	2.81	2.76	34	$3.31	$3.19	$3.29	$3.18	60	$4.88	$4.54	$4.65	$4.36
9	2.83	2.77	2.82	2.77	35	3.34	3.22	3.32	3.20	61	4.99	4.63	4.74	4.45
10	2.84	2.78	2.83	2.78	36	3.38	3.24	3.35	3.23	62	5.11	4.73	4.84	4.54
11	2.85	2.79	2.78	2.79	37	3.41	3.27	3.35	3.26	63	5.22	4.84	4.94	4.64
12	2.86	2.80	2.86	2.80	38	3.45	3.30	3.42	3.29	64	5.35	4.95	5.04	4.75
13	2.88	2.82	2.87	2.81	39	3.49	3.34	3.42	3.32	65	5.49	5.07	5.15	4.84
14	2.89	2.83	2.88	2.82	40	3.53	3.37	3.46	3.35	66	5.62	5.20	5.28	4.96
15	2.90	2.84	2.90	2.84	41	3.57	3.41	3.53	3.34	67	5.77	5.33	5.40	5.09
16	2.92	2.85	2.91	2.85	42	3.62	3.44	3.57	3.42	68	5.91	5.47	5.52	5.20
17	2.93	2.87	2.93	2.86	43	3.66	3.48	3.59	3.46	69	6.07	5.62	5.67	5.32
18	2.95	2.88	2.94	2.88	44	3.71	3.52	3.63	3.46	70	6.23	5.78	5.80	5.45
19	2.97	2.89	2.96	2.89	45	3.76	3.57	3.67	3.54	71	6.39	5.94	5.95	5.61
20	2.98	2.91	2.97	2.90	46	3.81	3.61	3.73	3.58	72	6.56	6.11	6.11	5.77
21	3.00	2.92	2.99	2.92	47	3.87	3.66	3.78	3.59	73	6.73	6.29	6.28	5.91
22	3.02	2.94	3.01	2.93	48	3.92	3.71	3.83	3.63	74	6.90	6.48	6.45	6.09
23	3.04	2.96	3.03	2.95	49	3.99	3.76	3.89	3.68	75	7.08	6.67	6.63	6.29
24	3.06	2.97	3.05	2.97	50	4.05	3.81	3.94	3.77	76	7.25	6.86	6.83	6.47
25	3.08	2.99	3.07	2.93	51	4.11	3.87	4.00	3.79	77	7.43	7.06	7.03	6.65
26	3.10	3.01	3.09	3.00	52	4.18	3.93	4.07	3.84	78	7.60	7.26	7.26	6.89
27	3.12	3.03	3.11	3.02	53	4.25	3.99	4.13	3.91	79	7.78	7.46	7.47	7.13
28	3.15	3.05	3.13	3.04	54	4.33	4.06	4.18	3.97	80	7.94	7.66	7.70	7.34
29	3.17	3.07	3.16	3.06	55	4.41	4.13	4.25	4.03	81	8.11	7.85	7.95	7.60
30	3.20	3.09	3.18	3.08	56	4.49	4.20	4.32	4.10	82	8.27	8.04	8.22	7.89
31	3.22	3.11	3.21	3.06	57	4.58	4.28	4.39	4.17	83	8.42	8.23	8.49	8.16
32	3.25	3.14	3.19	3.13	58	4.68	4.36	4.47	4.22	84	8.56	8.39	8.77	8.45
33	3.28	3.16	3.26	3.15	59	4.78	4.44	4.56	4.30	85 and over	8.69	8.56	9.07	8.78

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WHOLE LIFE INSURANCE POLICY

- **Life Insurance Payable at the Death of the Insured**
- **Policy Matures on the Policy Anniversary Date Following the Insured's 100th Birthday**
- **Premiums Payable to the Policy Anniversary Date Following the Insured's 100th Birthday**
- **Non-Participating - No Dividends**

1 For United of Omaha Career Brokers Only: _____ Manager Stamp _____ DSM Stamp _____ Agent Stamp

United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

Application For: ☐ Medicare Supplement Coverage ☐ Life Insurance

Mgr./Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc. Marketer	Application Reviewed By:

MEDICARE SUPPLEMENT PLAN INFORMATION (to be completed by **Producer**)

NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.

APPLICANT	APPLICANT B
Policy Form	**Policy Form**
Requested Effective Date	Requested Effective Date
Medicare Supplement Premium Collected $	Medicare Supplement Premium Collected $
2 [Initial] Mode **A, S, Q, B** 3 [, **ACH**] 4 [**or CC**]	2 [Initial] Mode **A, S, Q, B** 3 [, **ACH**] 4 [**or CC**]
2 Renewal $	Renewal $
Renewal Mode **A, S, Q, B** 4 [**or CC**] (monthly not available)	Renewal Mode **A, S, Q, B** 4 [**or CC**] (monthly not available)

1. IF APPLYING FOR MEDICARE SUPPLEMENT AND/OR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Applicant	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address (if different from applicant's)
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (_____)_____ (area code)	Home Phone No (_____)_____ (area code)
Current Age _____ Date of Birth_____/____/_____ mo day yr	Current Age _____ Date of Birth_____/____/_____ mo day yr
Male ☐ Female ☐	Male ☐ Female ☐
Social Security No.	Social Security No.
Medicare Health Insurance Card Number (if known or applicable)	Medicare Health Insurance Card Number (if known or applicable)
E-mail Address	E-mail Address
Height Ft _____ In _____ Weight Lbs _____	Height Ft _____ In _____ Weight Lbs _____

2. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

	APPLICANT	APPLICANT B
1. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the Outline of Coverage?	Yes ☐ No ☐	Yes ☐ No ☐
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part A effective date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
If "NO," what is your eligibility date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
2. Are you covered under Medicare Part B?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part B effective date? ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
If "NO," indicate date you plan to enroll. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
3. Did you turn age 65 in the last 6 months?	Yes ☐ No ☐	Yes ☐ No ☐
4. Did you enroll in Medicare Part B in the last 6 months?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," indicate your effective date. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.**

3. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE ANSWER THE FOLLOWING QUESTIONS. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES" please attach proof of eligibility.)	Yes ☐ No ☐	Yes ☐ No ☐
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force?	Yes ☐ No ☐	Yes ☐ No ☐
(a) If "YES," with what company, and what plan do you have?		

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date ____/____/____	Issue Date ____/____/____

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	Yes ☐ No ☐	Yes ☐ No ☐
(c) If "YES," indicate termination date. ____/____/____ (Applicant) / ____/____/____ (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐

If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.

3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ____/____/____ END ____/____/____ (Applicant) / START ____/____/____ END ____/____/____ (Applicant B)

(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐

(c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B)

(d) Planned date of termination/disenrollment? _____ (Applicant) / _____ (Applicant B)

(e) Was this your first time in this type of Medicare plan? Yes☐ No☐ Yes☐ No☐

(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes☐ No☐ Yes☐ No☐

(g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes☐ No☐ Yes☐ No☐

4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan) Yes☐ No☐ Yes☐ No☐

(a) If "YES," with what company and what kind of policy? (List below)

Applicant		**Applicant B**	
Name of Company	Kind of Policy	Name of Company	Kind of Policy

(b) What are your dates of coverage under the other policy? If you are still covered under this plan, leave "END" blank.
START _____/____/_____ END _____/____/_____ / START _____/____/_____ END _____/____/_____
Applicant Applicant B

(c) Reason for termination/disenrollment? _____ / _____
Applicant Applicant B

(d) Planned date of termination/disenrollment? _____/____/_____ / _____/____/_____
Applicant Applicant B

5. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) Yes☐ No☐ Yes☐ No☐

If "YES,"

(a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes☐ No☐ Yes☐ No☐

(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes☐ No☐ Yes☐ No☐

6. Producers shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

(b) List policies sold in the past five (5) years which are no longer in force.

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

4. IF APPLYING FOR MEDICARE SUPPLEMENT:

- **During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.**
- **NOT during Open Enrollment or a Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS.**

IF APPLYING FOR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS.

If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for Medicare Supplement or Life Insurance coverage.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair?	Yes ☐ No ☐	Yes ☐ No ☐
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes ☐ No ☐	Yes ☐ No ☐
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do **not** have diabetes, this question should be answered "NO".	Yes ☐ No ☐	Yes ☐ No ☐
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes ☐ No ☐	Yes ☐ No ☐
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	Yes ☐ No ☐	Yes ☐ No ☐
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	Yes ☐ No ☐	Yes ☐ No ☐
10. Within the past two years have you been treated for degenerative bone disease, crippling/ disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	Yes ☐ No ☐	Yes ☐ No ☐
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes ☐ No ☐	Yes ☐ No ☐
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes ☐ No ☐	Yes ☐ No ☐
13. Have you been hospital confined three or more times in the last two years?	Yes ☐ No ☐	Yes ☐ No ☐
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes ☐ No ☐	Yes ☐ No ☐
15. Have you used tobacco in any form in the past 12 months?	Yes ☐ No ☐	Yes ☐ No ☐
16. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table.	Yes ☐ No ☐	Yes ☐ No ☐

Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
_____	Medication Name (copy off pharmacy label)	_____
_____	Date **Originally** Prescribed	_____
_____	Frequency and Dosage	_____
	Diagnosis/Condition	
_____	Medication Name (copy off pharmacy label)	_____
_____	Date **Originally** Prescribed	_____
_____	Frequency and Dosage	_____
	Diagnosis/Condition	
_____	Medication Name (copy off pharmacy label)	_____
_____	Date **Originally** Prescribed	_____
_____	Frequency and Dosage	_____
	Diagnosis/Condition	

5. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE COMPLETE HOUSEHOLD DISCOUNT INFORMATION

You may be eligible for a policy with a lower rate based on your answers to the statements in this section.	Applicant	Applicant B
a. I have continuously resided with another person for the last 12 months or are married and they are also applying for this coverage. If "YES," please provide the following information. If you and Applicant B are applying for coverage on this application, do not fill out the following information.	Yes ☐ No ☐	Yes ☐ No ☐

Relationship to Applicant:		
First Name		
Last Name		
Street Address		
City	State	ZIP

b. I have continuously resided with another person for the last 12 months or are married and they have an existing Medicare supplement policy or certificate with Mutual of Omaha Insurance Company or United World Life Insurance Company or United of Omaha Life Insurance Company. If "YES," please provide the following information.	Applicant	
	Yes ☐ No ☐	

Relationship to Applicant:		
First Name		
Last Name		
Street Address		
City	State	ZIP
Policy/Certificate Number		

6. IF APPLYING FOR LIFE INSURANCE, PLEASE COMPLETE ALL QUESTIONS

If you are in Open Enrollment or eligible for Guaranteed Issue for a Medicare Supplement policy and are applying for Life Insurance, you must answer all the questions in Section 4 of the application.

APPLICANT	APPLICANT B (if applying for coverage)
Beneficiary Name (If no beneficiary is named, proceeds will be paid to the Insured's estate.)	Beneficiary Name (If no beneficiary is named, proceeds will be paid to the Insured's estate.)
Relationship to Applicant	Relationship to Applicant B
5 Face Amount: [☐ [$5,000] ☐ [$10,000] ☐ Other _____] 5	Face Amount: [☐ [$5,000] ☐ [$10,000] ☐ Other _____]
Life Insurance Premium Collected: $	Life Insurance Premium Collected: $
6 [Initial] Mode: **A, S, Q, B 7[, ACH] or 8[CC]** 6	[Initial] Mode: **A, S, Q, B 7[, ACH] or 8[CC]**
6 Renewal: $	Renewal: $
Renewal Mode: **A, S, Q, B 8[or CC]** (monthly not available)	Renewal Mode: **A, S, Q, B 8[or CC]** (monthly not available)

	Applicant	Applicant B
1. Are you a citizen of the United States? If "No," complete Foreign National and Foreign Travel Questionnaire	Yes ☐ No ☐	Yes ☐ No ☐

2. List below all life insurance policies and/or annuity contracts on the Applicants that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) **If none, check the following box: ☐None**
3. List below if you have had or intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application.
   The Producer shall comply with any additional state and/or company replacement requirements.

Company	Applicant	Policy or Contract Number	Face Amount	Pending?	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Any person who, with intent to defraud or knowingly that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement is guilty of insurance fraud.

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by United of Omaha Life Insurance Company.

Dated at _____, on _____, _____ _____
City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____ _____
City State Month Day Year Applicant's B's Signature (if applying)

I wish to apply for a Life insurance policy. I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. The life insurance policy applied for will not take effect until it is issued by us and all of the following requirements are met: (a) the policy is delivered to and accepted by the policy owner; (b) the first full premium has been paid according to the mode of payment specified in the application; (c) the Proposed Insured is still alive; and (d) there has been no change in the Proposed Insured's health or habits, or the answers to any of the questions in the application, from the date the application is approved by United of Omaha's Underwriting Department to the date the policy is delivered and accepted by the policy owner.

Dated at _____, on _____, _____ _____
City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____ _____
City State Month Day Year Applicant's B's Signature (if applying)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

_____ _____
(Signature of Licensed Producer) (Signature of Licensed Producer)

_____ _____
PRODUCER STAMP PRODUCER STAMP

ADDITIONAL INFORMATION: PART 4 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #15

Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

SECTION FOR ADDITIONAL COMMENTS

Applicant (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

Addendum Application for Life Insurance

Please complete the following information if applying for life insurance based on a previously approved United of Omaha Life Insurance Company Application for Medicare Supplement Coverage and within 30 days of application sign date.

Do not complete Addendum Application if Medicare Supplement was issued through Open Enrollment or Guaranteed Issue, please complete an entire new Medicare Supplement/Life combination application.

Applicant	Applicant B (if applying for coverage)
Medicare Supplement Policy Number	Medicare Supplement Policy Number
Beneficiary Name (If no beneficiary is named, proceeds will be paid to the Insured's estate.)	Beneficiary Name (If no beneficiary is named, proceeds will be paid to the Insured's estate.)
Relationship to Applicant	Relationship to Applicant B
Social Security Number	Social Security Number
9 Face Amount: [☐ [$5,000] ☐ [$10,000] ☐ Other _____] 9	Face Amount: [☐ [$5,000] ☐ [$10,000] ☐ Other _____]
Life Insurance Premium Collected: $	Life Insurance Premium Collected: $
10 [Initial] Mode: ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ BSP 10 11 [☐ ACH] 12 [☐ Credit Card]	[Initial] Mode: ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ BSP 11 [☐ ACH] 12 [☐ Credit Card]
Renewal: $	Renewal: $
10 Renewal Mode: ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ BSP 12 [☐ Credit Card] (monthly not available)	Renewal Mode: ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ BSP 12 [☐ Credit Card] (monthly not available)

	Applicant	Applicant B
1. Are you a citizen of the United States?.....	Yes ☐ No ☐	Yes ☐ No ☐

If "No," complete Foreign National and Foreign Travel Questionnaire

2. List below all life insurance policies and/or annuity contracts on the Applicant(s) that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) If none, check the following box: ☐ None

3. List below if you have had or intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application.
The Producer shall comply with any additional state and/or company replacement requirements.

Company	Applicant	Policy or Contract Number	Face Amount	Pending?	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I wish to apply for a life insurance policy as shown above based on my United of Omaha Life Insurance Company Application for Medicare Supplement. I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. This addendum application, along with my application for Medicare Supplement, will be attached and become part of my life insurance policy. The life insurance policy will not take effect until it is issued by United of Omaha and all of the following requirements are met: (a) the policy is delivered to and accepted by the policy owner; (b) the first full premium has been paid according to the mode of payment specified in the application; (c) the Proposed Insured is still alive; and (d) there has been no change in the Proposed Insured's health or habits, or the answers to any of the questions in the Medicare Supplement application, from the date the application was approved by United of Omaha's Underwriting Department to the date the life policy is delivered and accepted by the policy owner(s).

If, prior to policy delivery, the Applicant or Applicant B dies, or there has been a change in the health or habits of the Applicant(s), the producer cannot deliver the policy and must return it to United of Omaha's Home Office.

Signed at: _____ Date: _____
City State

_____ _____
Signature of Applicant Signature of Applicant B (if applicable)

SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
Company Tracking Number:	*BRANDI LASHLEY*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Individual Life Insurance - C501LAR08P*		
Project Name/Number:	*2008 United Med Supp-Whole Life Combo/C501LAR08P*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
Company Tracking Number:	*BRANDI LASHLEY*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Individual Life Insurance - C501LAR08P*		
Project Name/Number:	*2008 United Med Supp-Whole Life Combo/C501LAR08P*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 05/08/2008

Comments:

Attachment:

AR Certif of Compliance with Rule 19.pdf

Review Status:

Satisfied -Name: Application 05/08/2008

Comments:

Please see Form Schedule Tab.

Review Status:

Satisfied -Name: Life & Annuity - Acturial Memo 05/08/2008

Comments:

Attachment:

AR Actuarial Memorandum C501LAR08P.pdf

Review Status:

Satisfied -Name: Cover Letter 05/23/2008

Comments:

Attachment:

AR Whole Life Insurance Cover Letter.pdf

Review Status:

Satisfied -Name: Memo of Variability for Data Pages 05/23/2008

Comments:

Attachment:

Memo of Variability for Data Pages.pdf

Review Status:

Satisfied -Name: Memo of Variability for Applications 05/23/2008

SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
Company Tracking Number:	*BRANDI LASHLEY*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Individual Life Insurance - C501LAR08P*		
Project Name/Number:	*2008 United Med Supp-Whole Life Combo/C501LAR08P*		

Comments:

Attachment:

Memo of Variability for Applications.pdf

SERFF Tracking Number:	*MUTM-125639422*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	*39090*
Company Tracking Number:	*BRANDI LASHLEY*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Individual Life Insurance - C501LAR08P*		
Project Name/Number:	*2008 United Med Supp-Whole Life Combo/C501LAR08P*		

Review Status:

Satisfied -Name: AR Credit Card Cert 05/23/2008

Comments:

Attachment:

AR Credit Card Cert.pdf

Review Status:

Satisfied -Name: AR Fee Schedule Cert 05/23/2008

Comments:

Attachment:

AR Fee Schedule Cert .pdf

Review Status:

Satisfied -Name: AR Read Cert 05/23/2008

Comments:

Attachment:

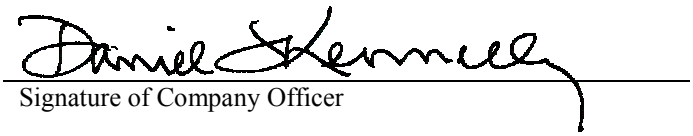
AR Read Cert.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: United of Omaha Life Insurance Company

Form Number(s): C501LAR08P

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Daniel J. Kennelly

Name

Vice President and Chief Compliance Officer

Title

May 23, 2008

Date

UNITED OF OMAHA LIFE INSURANCE CO.
ACTUARIAL MEMORANDUM
FORM C501LAR08P

I. Introduction

- A. Product Description
- B. Issue Ages
- C. Reserves and Cash Values

II. Mortality Tables and Interest Rates

III. Statutory Reserves

- A. General Description of Basis
- B. Formulas and Examples

IV. Nonforfeiture Values

- A. General Description of Basis
- B. Formulas and Examples

I. Introduction

Product Description: Whole life insurance with premiums payable to age 100 and endowment at age 100. Face amount is assumed to be $1,000. Premiums must continue to be paid in order to keep the policy in force.

Issue Ages: 64-85

Reserves and Cash Values: The reserves and cash values for this policy have been set in accordance with the Standard Valuation Model Regulation and Standard Nonforfeiture Model Regulation adopted by the National Association of Insurance Commissioners including all changes incorporated.

II. Mortality Tables and Interest Rates

The valuation mortality table is the 2001 Commissioners Standard Ordinary Mortality Table, Age Last Birthday, Male and Female. The valuation interest rate is 4.00%.

The nonforfeiture mortality table is the 2001 Commissioners Standard Ordinary Mortality Table, Age Last Birthday, Male and Female. The nonforfeiture interest rate is 5.00%.

III. Statutory Reserves

Terminal reserves for each policy will be defined as the greater of (A) and (B) where

(A) is the CRVM reserve, using fully continuous commutation functions and the valuation mortality table and interest rate; and
(B) is the cash value of the policy.

Modified Net Premium:
For policy year 1:

$$\overline{\overline{\alpha}}_t = \frac{1000 \times \overline{\overline{C}}_x}{\overline{\overline{D}}_x}$$

For policy year 2 through 100-x:

$$\overline{\overline{\beta}}_x = \frac{1000 \times \overline{\overline{A}}_{x+1}}{\overline{\overline{a}}_{x+1}}$$

Terminal Reserve at the end of policy year t*:

$${}_t\overline{\overline{V}}(\overline{\overline{A}}_x) = \overline{\overline{\alpha}}_x \times \frac{\overline{\overline{D}}_x}{\overline{\overline{D}}_{x+t}} + \overline{\overline{\beta}}_x \times \frac{\overline{\overline{N}}_{x+1} - \overline{\overline{N}}_{x+t}}{\overline{\overline{D}}_{x+t}} - 1000 \times \frac{\sum_{s=1}^{t} \overline{\overline{C}}_{x+s-1}}{\overline{\overline{D}}_{x+t}}$$

Examples:

Assumptions: Male, age 65
$1,000 specified amount

I. ${}_5\overline{V}_{65}$ = greater of

a) $${}_5\overline{V}(\overline{A_{65}}) = \overline{\alpha}_{65} \times \frac{\overline{D}_{65}}{\overline{D}_{70}} + \overline{\beta}_{65} \times \frac{\overline{N}_{66} - \overline{N}_{70}}{\overline{D}_{70}} - 1000 \times \frac{\sum_{s=1}^{5} \overline{C}_{65+s-1}}{\overline{D}_{70}}$$

b) $${}_5CV_{65} = 92$$

$$\overline{\alpha}_{65} = \frac{\overline{C}_{65} \times 1000}{\overline{D}_{65}} = \quad 17.80611 \qquad \overline{\beta}_{65} = \frac{\overline{M}_{66} \times 1000}{\overline{N}_{66}} = \ 51.24708$$

$$\frac{\overline{D}_{65}}{\overline{D}_{70}} = 1.35964 \qquad \frac{\overline{N}_{66} - \overline{N}_{70}}{\overline{D}_{70}} = 4.69702 \qquad 1000 \times \frac{\sum_{s=1}^{5} \overline{C}_{65+s-1}}{\overline{D}_{70}} = 127.62529$$

${}_5\overline{V}(\overline{A}_{65})$ = \$138 (17.80611 x 1.35964 + 51.24708 * 4.69702 – 127.62529)

Therefore, ${}_5\overline{V}_{65}$ = \$138 (the greater of \$138 and \$92)

II. ${}_{20}\overline{V}_{65}$ = greater of

a) $${}_{20}\overline{V}(\overline{A}_{65}) = \overline{\alpha}_{65} \times \frac{\overline{D}_{65}}{\overline{D}_{85}} + \overline{\beta}_{65} \times \frac{\overline{N}_{66} - \overline{N}_{85}}{\overline{D}_{85}} - 1000 \times \frac{\sum_{s=1}^{20} \overline{C}_{65+s-1}}{\overline{D}_{85}}$$

b) $${}_{20}CV_{65} = 541$$

$$\overline{\alpha}_{65} = \ 17.80611 \qquad \overline{\beta}_{65} = 51.24708 \qquad \frac{\overline{D}_{65}}{\overline{D}_{85}} = 6.51719$$

$$\frac{\overline{N}_{66} - \overline{N}_{85}}{\overline{D}_{85}} = 65.18453 \qquad 1000 \times \frac{\sum_{s=1}^{20} \overline{C}_{65+s-1}}{\overline{D}_{85}} = 2806.68564$$

${}_{20}\overline{V}(\overline{A}_{65})$ = \$650 (17.80611 x 6.51719 + 51.24708 * 65.18453 – 2806.68564)

Therefore, ${}_{20}\overline{V}_{65}$ = \$650 (the greater of \$650 and \$541)

IV. Nonforfeiture Factors

Cash values for each policy will be defined as the present value guaranteed future benefits less present value future adjusted premiums, using curtate commutation functions and the nonforfeiture mortality table and interest rate.

$$P_x^{NNL} = \left(1000 \times \sum_{t=1}^{100-x} \frac{C_{x+t-1}}{D_x} \right) \div \ddot{a}_x$$

$$EA_x = .01 \times ELA_x + 1.25 \times \left[\frac{P_x^{NNL}}{.04 \times ELA_x} \right]$$, where [] means the smaller of the two quantities

$$ELA_x = \left(\sum_{t=1}^{10} {}_t DB_x \right) \div 10$$, the Equivalent Level Amount

$$P_x^A = P_x^{NNL} + \frac{EA_x}{\ddot{a}_x}$$

Cash Values at the end of t Years*:

$${}_t CV_x = \left(1000 \times \sum_{s=t+1}^{100-x} C_{x+s-1} - P_x^A \times N_{x+t} \right) \div D_{x+t}$$

Examples:

Assumptions: Male, age 65
$1,000 specified amount

$$P_{65}^{NNL} = \left(1000 \times \sum_{t=1}^{35} \frac{C_{65+t-1}}{D_{65}} \right) \div \ddot{a}_{65} = 42.82028$$

$$ELA_{65} = \left(\sum_{t=1}^{10} {}_t DB_{65} \right) \div 10 = 1000$$

$$EA_{65} = .01 \times ELA_{65} + 1.25 \times \left[\frac{P_{65}^{NNL}}{.04 \times ELA_{65}} \right] = 60.00$$

$$P_{65}^A = P_{65}^{NNL} + \frac{EA_{65}}{\ddot{a}_{65}} = 48.24663$$

$${}_5 CV_{65} = \left(1000 \times \sum_{s=6}^{35} C_{65+s-1} - P_{65}^A \times N_{70} \right) \div D_{70} = 92$$

$${}_{20} CV_{65} = \left(1000 \times \sum_{s=21}^{35} C_{65+s-1} - P_{65}^A \times N_{85} \right) \div D_{85} = 541$$

*Cash values and terminal reserves per $1,000 are adjusted to the over dollar.

Bob Nicas, FSA MAAA
April 25, 2008

UNITED *of* OMAHA LIFE INSURANCE COMPANY
Mutual of Omaha Plaza
Omaha, NE 68175
402 342 7600

May 23, 2008

Arkansas Department of Insurance
Attn: Compliance - Life & Health
1200 West Third Street
Little Rock, AR 72201-1904

RE: **United of Omaha Life Insurance Company**
NAIC No. 261-69868 FEIN 47-0322111
Individual Life Insurance
Form C501LAR08P Whole Life Insurance Policy
Form UA5916-03 Whole Life Insurance/Medicare Supplement Application
Form C447LNA08A Whole Life Insurance Addendum Application

On behalf of United of Omaha Life Insurance Company, I am submitting the above-captioned forms in final printed format for review and approval. The individual life policy and accompanying applications are new and not intended to replace any previously approved forms.

Policy Form C501LAR08P

Policy form C501LAR08P is a simplified underwritten fixed premium whole life plan. Premiums are payable to age 100. The premiums are level and there are no bands.

This product will be offered in the general insurance market by independent brokers and our career agents. Initially, we will offer this form to individuals who are ages 64 to 85. Initially, the available face amounts are $2,500 to $25,000.

This policy does not contain any nonguaranteed elements and is considered non-illustrated within the meaning of the NAIC Life Insurance Illustrations Model Regulation.

Please see the attached Data Pages Memorandum of Variability which identifies the sections of the data pages that are variable and explains the reason for the variability.

Application Form UA5916-03

Application Form UA5916-03 will be used with policy Form C501LAR08P and our Medicare Supplement and Medicare Select products in your state.

If the applicant chooses to purchase life insurance, they will be required to fill out the health questions in application Form UA5916-03 regardless if they are in an open enrollment or guaranteed issue period for the Medicare Supplement. There are instructions on the application informing the applicant when they may or may not need to complete the underwriting questions.

Please see the attached Application Memorandum of Variability which identifies the sections of the application that are variable and explains the reason for the variability.

Application Form C447LNA08A

Application Form C447LNA08A is a life insurance addendum application used with for Form UA5916-03 for policy Form C501LAR08P. If an applicant applies for a Medicare Supplement policy using Form UA5916-03 and decides at a later time within one month of their application that they would like to purchase policy Form C501LAR08P, they can use application Form C447LNA08A which will attach to their original application Form UA5916-03 and become part of their policy.

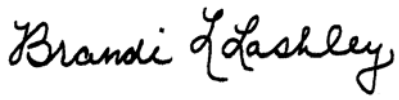
This application will only be used if the applicant was not in an open enrollment or guaranteed issue period for Medicare Supplement.

These forms are not for use in Nebraska, our state of domicile. Therefore they have not been filed for approval with the Nebraska Department of Insurance.

The Flesch scores of these forms meet or exceed your state's Flesch readability requirements.

The required filing materials and supporting actuarial memoranda are enclosed. Thank you for your consideration of this submission. If you have any questions or concerns, please don't hesitate to contact me.

Sincerely,



Brandi L. Lashley, ACS, AIRC
Senior Product and Advertising Compliance Analyst
Regulatory Affairs

Phone: 402-351-4005
Fax: 402-351-5298
E-mail: brandi.lashley@mutualofomaha.com

STATEMENT OF VARIABILITY FOR DATA PAGES

The following information is denoted by brackets in the policy accompanying this filing.

1. Policy Data	All variables identified contain information specific to each insured and are standard for Whole Life Insurance Policies.
2. Schedule of Benefits	
• Annual Premium	Variable based on face amount designated on application, insured's issue age, sex, rate class and risk class.
• Years Payable	Variable based on issue age.
• Total Annual Premium	Variable based on face amount designated on application, insured's issue age, sex, rate class and risk class.
• Premiums by Premium Payment	Variables identified contain the premium amounts for the payment modes on the application and are based on the face amount, insured's issue age, sex, rate class and risk class.
• Modal policy fee of $[36.00]	Variable based on the mode of premium payment chosen by the applicant. This variable ranges from $3.00 for monthly premium modes to $36.00 for the annual premium mode.
• Issue Date and each [12 months]	Variable based on the mode of premium payment selected.
3. Table of Policy Values	Variables identified are based on insured's issue age and sex.
4. Nonforfeiture Factor	Variable based on the insured's issue age and sex and to allow for future nonforfeiture interest rate updates.
5. Nonforfeiture Interest Rate	Variable to allow for future nonforfeiture interest rate updates.
6. Mortality Table [2001]	Variable to allow for future CSO Mortality Table updates.

Memorandum of Variability
Explanation of Variable Statements and Fields
For United of Omaha Life Insurance Company
Application and Addendum Form

Each variable section, statement or field is denoted by [brackets] and annotated with numbers in RED. The explanations below follow the order in which the variable fields appear in the form.

Reference to Independent Distribution Network (IDN) is our Brokerage distribution channel.

Reference to Automated Clearing House (ACH) is a nationwide batch oriented electronic funds transfer system which provides for inter-bank clearing of electronic payments for participating depository financial institutions.

Variable Statements/Fields	***How or When Used***
PAGE 1	
1.[For United of Omaha Career Brokers Only: ... *etc*]	May or may not print depending on administrative use.
For APPLICANT and APPLICANT B 2. [Initial] Mode A, S, Q, B 2. [Renewal $_____] [Renewal Mode A, S, Q, B]	Either both of these variables will print or both will not, depending on whether we will offer different initial and renewal premium payment modes at application. May or may not print depending on distribution or marketing criteria.
3. [, ACH]	May or may not print as payment option for IDN distribution only.
4. [or CC]	May or may not print as Credit Card payment option for future use depending on marketing criteria.
PAGE 5	
For APPLICANT and APPLICANT B 5. Face Amount [☐ [$5,000] ☐ [$10,000] ☐ Other_____]	The number of face amount options and the face amounts listed may change depending on distribution and marketing criteria.
For APPLICANT and APPLICANT B 6. [Initial] Mode A, S, Q, B 6. [Renewal $_____] [Renewal Mode A, S, Q, B]	Either both of these variables will print or both will not, depending on whether we will offer different initial and renewal premium payment modes at application. May or may not print depending on distribution or marketing criteria.
7. [, ACH]	May or may not print as payment option for IDN distribution only.
8. [or CC]	May or may not print depending on distribution or marketing criteria.

Addendum Application for Life Insurance	
For APPLICANT and APPLICANT B 9. Face Amount [☐ [$5,000] ☐ [$10,000] ☐ Other_____]	The number of face amount options and the face amounts listed may change depending on distribution and marketing criteria.
For APPLICANT and APPLICANT B 10. [Initial] Mode A, S, Q, B 10. [Renewal $_____] [Renewal Mode A, S, Q, B]	Either both of these variables will print or both will not, depending on whether we will offer different initial and renewal premium payment modes at application. May or may not print depending on distribution or marketing criteria.
11. [, ACH]	May or may not print as payment option for IDN distribution only.
12. [or CC]	May or may not print as Credit Card payment option for future use depending on marketing criteria.

Arkansas Insurance Department

Mike Huckabee
Governor

Julie Benafield Bowman
Commissioner

Please read and acknowledge your understanding and assurance of complying with the following requirements:

1. If a sponsor or endorser is involved such as a bank, school, retail store, etc., it must be ascertained whether that sponsor is to receive any form of compensation for the use of the card. If so, this must be disclosed to the insured. If there is compensation, the sponsor would need to be licensed to sell insurance.

2. The company must certify that failure to pay the credit card bill will not affect the premium payment.

3. If the credit card company does not pay the premium for any reason, the insurance company must notify the insured of this and allow a thirty day Grace Period for the insured to pay the premium.

Daniel K Kennelly — May 23, 2008

SIGNATURE — DATE

United of Omaha Life Insurance Company

COMPANY

CC-1

1200 West Third Street, Little Rock, AR 72201-1904 · (501) 371-2600 · (501) 371-2618 fax · www.arkansas.gov/insurance
Information (800) 282-9134 · Consumer Services (800) 852-5494 · Seniors (800) 224-6330 · Fraud (866) 660-0888

ARKANSAS
INSURANCE
DEPARTMENT

400 University Tower Building
1123 South University Ave.
Little Rock, Arkansas 72204

Lee Douglass
Insurance Commissioner

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

Company Name: United of Omaha Life Insurance Company

Company NAIC Code: 261-69868
Company Contact Person & Phone: Brandi Lashley 402-351-4005

INSURANCE DEPARTMENT USE ONLY:

ANALYST: _____ AMOUNT: _____ ROUTE SLIP: _____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LIFE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.	* 1 X $50 = $ 50.00 **Retaliatory $ _____
Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.	* _____ X $50 = _____ **Retaliatory $ _____
Life and/or Disability Policy, Contract or Annuity Forms : Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.	* _____ X $20 = _____ **Retaliatory $ _____
Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.	* Chief X $25 = $ _____ **Retaliatory $ _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority	* _____ X $400 = _____
Filing to amend Certificate of Authority.	*** ____ X $100 = _____

***THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.**

****THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.**

*****THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN. SEC. 23-61-401.**

ARKANSAS

CERTIFICATION

This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form	Description	Score
C501LAR08P	Whole Life Insurance Policy	51.0
UA5916-03	Whole Life Insurance/Medicare Supplement Application	50.6*
C447LNA08A	Whole Life Insurance Addendum Application	49.8**

* When scored with the policy. ** When scored with the policy and base application.

United of Omaha Life Insurance Company

Date: May 23, 2008

Daniel J. Kennelly
Vice President & Chief Compliance Officer